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|  |  |  |  |
| --- | --- | --- | --- |
| Filled in by:  |       | Contact number:  | (000) 000 0000 |
| Date:  | DD / MM / YYYY | Information collected from:  |       |
| **PATIENT DETAILS** |
| 1. SURNAME, FIRST NAME:  |       |
| 2. AGE/DOB | 00 | years | / | DD / MM / YYYY | 3. GENDER: [ ]  MALE [ ]  FEMALE |
| 4. CONTACT NUMBER:  | (000) 000 0000 | (000) 000 0000 | (000) 000 0000 |
| 5. OCCUPATION:  |       | 6. FARM NAME: |  |
| 7. TOWN:  |       | DISTRICT: |       | PROVINCE: |       |
| **CONSULTATION/ADMISSION DETAILS** |
| 8. NAME CLINICIAN:  |       | 9. CELL/TEL NUMBER: | (000) 0000000 | (000) 0000000 |
| 10. FACILITY NAME: |       |
| 11. DATE OF FIRST CONSULTATION:  | DD / MM / YYYY | 12. SPECIMEN COLLECTION DATE: | DD / MM / YYYY |
| 13. ADMITTED TO HOSPITAL? [ ]  Y [ ]  N  | 14. REQUIRED ICU CARE? [ ]  Y [ ]  N  |
| If yes, DURATION OF HOSPITAL ADMISSION?  | 00 | (days) | If yes, DURATION OF ICU CARE? | 00 | (days) |
| **CLINICAL DETAILS ON FIRST PRESENTATION/ADMISSION** |
| **15. PAST MEDICAL HISTORY:** |
| UNDERLYING ILLNESS?  | [ ]  Y [ ]  N | … If yes, WHAT? |       |
| IMMUNOSUPPRESSION?  | [ ]  Y [ ]  N | … If yes, GIVE DETAILS? |       |
| PAST RVFV INFECTION? | [ ]  Y [ ]  N | … If yes, WHEN? | 00 | (month) | 0000 | (year) |
| **16. DATE OF ONSET OF ILLNESS?** DD / MM / YYYY |
| **17. SYMPTOMS (tick all that apply)**:  |
| [ ]  FEVER[ ]  MYALGIA[ ]  ARTHRALGIA[ ]  FATIGUE[ ]  MALAISE[ ]  LOSS OF APPETITE[ ]  NAUSEA[ ]  VOMITING | [ ]  ABDOMINAL PAIN[ ]  NECK STIFFNESS[ ]  HEADACHE[ ]  OCULAR PAIN[ ]  PHOTOPHOBIA[ ]  BLURRED VISION[ ]  LOSS OF VISUAL ACUITY[ ]  CONFUSION | **18.** **[ ]  HAEMORRHAGE (If yes, tick sites that apply):** |
|  |  | [ ]  EPISTAXIS[ ]  HAEMATEMESIS [ ]  MELAENA[ ]  MENORRHAGIA  | [ ]  PETECHIAE BLEEDING[ ]  FROM VENEPUNCTURE SITES |
|  |  | [ ]  BLEEDING ELSEWHERE? Specify: |
|  |  |       |
| **19. EXAMINATION ON PRESENTATION (tick all that apply):**  |
| [ ]  FEVER (≥ 38°C)[ ]  SHOCK (↓BP) | [ ]  DEHYDRATION [ ]  JAUNDICE [ ]  PALLOR | [ ]  MENINGISM [ ]  CONFUSION [ ]  RETINITIS | [ ]  HEPATOMEGALY [ ]  ABDOMINAL TENDERNESS [ ]  RASH |
| **20. LIST OTHER CLINICAL FINDINGS?** |
|  |
| **21. CLINICAL PROGRESSION TO DATE?** [ ]  UNEVENTFUL RECOVERY or [ ]  DEVELOPED COMPLICATIONS ... If developed complications, tick all that apply: |
| [ ]  ELEVATED TRANSAMINASE LEVELS (AST, ALT) [ ]  LIVER FAILURE [ ]  RENAL FAILURE  | [ ]  THROMBOCYTOPENIA[ ]  HAEMORRHAGE  | [ ]  RETINITIS [ ]  ENCEPHALITIS  |
| **22. OUTCOME:** [ ]  ALIVE [ ]  DIED … If yes, DATE OF DEATH? | DD / MM / YYYY |
| **23. EXPOSURE (tick all that apply)** |
| DATE OF EXPOSURE? | DD / MM / YYYY |
| [ ]  CONTACT WITH ANIMALS/ TISSUES [ ]  MOSQUITO BITES | [ ]  DRANK UNPASTEURISED MILK [ ]  CONSUMED ANIMAL MEAT NOT SOURCED FROM RETAIL OUTLET |
| DESCRIPTION OF EXPOSURE: |       |
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# RIFT VALLEY FEVER SUSPECTED CASE INVESTIGATION FORM, 2021